King County

1200 King County Courthouse
516 Third Avenue
Seattle, WA 98104

Meeting Agenda

Board of Health

Metropolitan King County Councilmembers: Joe McDermott, Chair;
Kathy Lambert, Julia Patterson
Alternate: Reagan Dunn

Seattle City Councilmembers: Sally Clark, Richard Conlin, Nick Licata
Alternate: Bruce Harrell

Suburban Elected Members: Suzette Cooke; Ava Frisinger
Alternate: David Baker

Health Professionals: Ben Danielson, MD; Frankie T. Manning, RN, M.A, Ray M. Nicola, MD, MHSA, FACPM

Director, Seattle-King County Department of Public Health: Dr. David Fleming
Staff: Maria Wood, Board Administrator (263-8791)

1:30 PM **Thursday, September 20, 2012** **Room 1001**

REVISED

To show a PDF of the written materials for an agenda item, click on the agenda item below.

1. **Call to Order**
2. **Roll Call**
3. **Announcement of Any Alternates Serving in Place of Regular Members**
4. **Approval of Minutes of July 19, 2012** pg 5
5. **Public Comments**
6. **Director's Report**

Sign language and communication material in alternate formats can be arranged given sufficient notice (296-1000).
TDD Number 296-1024.
ASSISTIVE LISTENING DEVICES AVAILABLE IN THE COUNCIL CHAMBERS.

Discussion and Possible Action

7. Resolution No. 12-09 pg 11

A RESOLUTION commending Seattle Children's launch of Mission: Nutrition, an initiative that supports Seattle Children's efforts to be a healthy organization for its patients, families, visitors and staff.

8. Resolution No. 12-10 pg 21

A RESOLUTION calling on the Washington state Legislature to restore local control of retail tobacco sales and promotion.

Joy Gilroy, Washington State Association of Local Public Health Officials (WSALPHO)

9. Resolution No. 12-11 pg 29

A RESOLUTION calling on the Drug Enforcement Administration to expedite its efforts to provide our communities with additional options for operation of secure, accessible, convenient medicine take-back programs that can safely dispose of all household medications, including controlled substances.

Briefings

10. BOH Briefing No. 12-B13 pg 35

The Shared Agenda of Public Health and Education: Eliminating Disparities

Mary Jean Ryan, Executive Director, Community Center for Education Results
TJ Cosgrove, Deputy Director, Community Health Services Division, Public Health – Seattle & King County

11. BOH Briefing No. 12-B14 pg 39

Health Care Reform - The King County Framework

Jennifer DeYoung, Health Reform Policy Analyst, Public Health – Seattle & King County
Susan McLaughlin, Health Care Integration Manager, Department of Community and Human Services, King County

12. BOH Briefing No. 12-B15 pg 52

Legislative Update

Jennifer Muhm, Legislative Affairs Officer, Public Health – Seattle & King County

13. Chair's Report

14. Board Member Updates

15. Administrator's Report

16. Other Business

17. Adjournment

If you have questions or need additional information about this agenda, please call 206-263-8791, or write to Maria Wood, Board of Health Administrator via email at maria.wood@kingcounty.gov

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King County

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Meeting Minutes

Board of Health

Metropolitan King County Councilmembers: Joe McDermott, Chair;
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Director, Seattle-King County Department of Public Health: Dr. David Fleming
Staff: Maria Wood, Board Administrator (263-8791)

1:30 PM **Thursday, July 19, 2012** **Room 1001**

DRAFT
REVISED

1. Call to Order

The meeting was called to order at 1:35 p.m.

2. Roll Call

Present: 7 - Ms. Lambert, Ms. Frisinger, Dr. Nicola, Ms. Patterson, Mr. McDermott, Mr. Conlin and Ms. Cooke

Excused: 3 - Ms. Clark, Mr. Licata and Dr. Danielson

3. Announcement of Any Alternates Serving in Place of Regular Members

4. Approval of Minutes of June 21, 2012

Boardmember Frisinger moved approval of the minutes of the June 21, 2012 meeting, as presented. The motion passed unanimously.

5. Public Comments

The following people spoke:
Sam Bellomio
Alex Zimmerman

Discussion and Possible Action

6. R&R No. BOH12-01

A RULE AND REGULATION relating to structural pest control; repealing R&R 05-05, Sections 47 and 48, and BOH 2.12.010, R&R 83, Section 1 (part), as amended, and BOH 2.12.020, R&R 83, Section 1 (part), as amended, and BOH 2.12.030, R&R 83, Section 1 (part), as amended, and BOH 2.12.040, R&R 83, Section 1 (part), as amended, and BOH 7.01.010, R&R amdt. Section 4, and BOH 7.01.015, R&R 83, Section 1 (part), as amended, and BOH 7.01.020, R&R 83, Section 1 (part), as amended, and BOH 7.01.030, R&R 83, Section 1 (part), as amended, and BOH 7.01.040, R&R 83, Section 1 (part), as amended, and BOH 7.01.050, R&R 83, Section 1 (part), and BOH 7.01.060, R&R 83, Section 1 (part), and BOH 7.01.090, R&R 83, Section 1 (part), and BOH 7.01.100, R&R 83, Section 1 (part), and BOH 7.05.005, R&R 83, Section 1 (part), as amended, and BOH 7.05.010, R&R 83, Section 1 (part), and BOH 7.05.020, R&R 83, Section 1 (part), as amended, and BOH 7.05.030, R&R 83, Section 1 (part), as amended, and BOH 7.05.040, R&R 83, Section 1 (part), as amended, and BOH 7.05.050, R&R 83, Section 1 (part), and BOH 7.10.010, R&R 83, Section 1 (part), as amended, and BOH 7.10.020, R&R 83, Section 1 (part), as amended, and BOH 7.10.030, R&R 83, Section 1 (part), as amended, and BOH 7.10.040, R&R 83, Section 1 (part), as amended, and BOH 7.20.010, R&R 83, Section 1 (part), and BOH 7.20.020, R&R 83, Section 1 (part), as amended, and BOH 7.20.030, R&R 83, Section 1 (part), as amended, and BOH 7.20.040, R&R 83, Section 1 (part), as amended, and BOH 7.20.050, R&R 83, Section 1 (part), as amended, and BOH 7.30.010 and R&R 83, Section 1 (part), as amended, and BOH 7.30.020; enacted pursuant to RCW 70.05.060, including the latest amendments or revisions thereto.

Larry Fay, Manager of Community Public Health Programs, Environmental Health Division of Public Health, briefed the Board on the rule and regulation.

Public Hearing
1. Anthony Worst spoke.

A motion was made by Mayor Frisinger that this R&R be Passed. The motion carried by the following vote:

Yes: 10 - Ms. Lambert, Ms. Frisinger, Dr. Nicola, Ms. Patterson, Mr. McDermott, Mr. Conlin and Ms. Cooke

Excused: 3 - Ms. Clark, Mr. Licata and Dr. Danielson

7. R&R No. BOH12-02

A RULE AND REGULATION relating to woodstoves; repealing R&R 70, Section 1 (part), and BOH 16.04.010, R&R 70, Section 1 (part), and BOH 16.04.020, R&R 70, Section 1 (part), and BOH 16.04.030, R&R 70, Section 1 (part), and BOH 16.04.040, R&R 70, Section 1 (part), and BOH 16.04.050, R&R 70, Section 1 (part), and BOH 16.08.010, R&R 70, Section 1 (part), and BOH 16.08.020, R&R 70, Section 1 (part), and BOH 16.08.030, R&R 70, Section 1 (part), and BOH 16.08.040, R&R 70, Section 1 (part), and BOH 16.08.050, R&R 70, Section 1 (part), and BOH 16.08.060, R&R 70, Section 1 (part), and BOH 16.08.070, R&R 70, Section 1 (part), and BOH 16.08.080, R&R 70, Section 1 (part), and BOH 16.08.090, R&R 70, Section 1 (part), and BOH 16.12.010, R&R 70, Section 1 (part), and BOH 16.12.020, R&R 70, Section 1 (part), and BOH 16.12.030, R&R 70, Section 1 (part), and BOH 16.12.040, R&R 70, Section 1 (part), and BOH 16.12.050, R&R 70, Section 1 (part), and BOH 16.12.060, R&R 70, Section 1 (part), and BOH 16.12.070, and R&R 70, Section 1 (part), and BOH 16.12.080; enacted pursuant to RCW 70.05.060, including the latest amendments or revisions thereto.

Mr. Fay briefed the Board on the rule and regulation.
Public Hearing
1. Andrew Green spoke.

A motion was made by Mayor Frisinger that this R&R be Passed. The motion carried by the following vote:

Yes: 10 - Ms. Lambert, Ms. Frisinger, Dr. Nicola, Ms. Patterson, Mr. McDermott, Mr. Conlin and Ms. Cooke

Excused: 3 - Ms. Clark, Mr. Licata and Dr. Danielson

8. Resolution No. 12-08

A RESOLUTION recognizing the Global to Local Health Initiative as an innovative strategy to improve health inequities in King County.

Adam Taylor, Global to Local Program Manager for Public Health, briefed the board and made a PowerPoint presentation.
Dr. Charissa Fontinos, Public Health Medical Director, spoke.

A motion was made by Mayor Frisinger that this Resolution be Passed. The motion carried by the following vote:

Yes: 8 - Ms. Frisinger, Dr. Nicola, Ms. Patterson, Mr. McDermott, Mr. Conlin and Ms. Cooke

Excused: 5 - Ms. Lambert, Ms. Clark, Mr. Licata and Dr. Danielson

Briefings

9. BOH Briefing No. 12-B10

2011 Health Care for the Homeless Annual Report, with a special focus on the Respite Program

Greg Francis, Advisory Planning Council Co- Chair, spoke.
Natalie Lente, Health Care for the Homeless Network Program Manager, briefed the board and made a PowerPoint presentation.
Edward Dwyer-O'Connor, Senior Manager of Downtown Programs for Harborview Medical Center, briefed the board and made a PowerPoint presentation.
The Chair invited community partners to speak.
Judy Fani, Seattle Housing Authority, made comments.

This matter was Presented

10. BOH Briefing No. 12-B11

Health Care Reform - Implications of the Supreme Court Decision

Jennifer DeYoung, health reform policy analyst, Department of Public Health, reported on the recent Supreme Court ruling on the Affordable Care Act and made a PowerPoint presentation.

This matter was Presented

11. BOH Briefing No. 12-B12

Legislative Update

Jennifer Muhm, legislative affairs officer, Department of Public Health, briefed the board on federal changes to the federal budget that may impact the Department. She also reported on cuts to the federal transportation budget and the farm progam.

This matter was Presented

12. Chair's Report

The Chair reported that he has convened a committee to look at policy options for the secure return of unused medications. He also reported on the King County ordinance restricting use of tobacco in King County parks. Finally, the Chair announced that the August meeting of the board will be cancelled.

13. Board Member Updates

14. Administrator's Report

Maria Woods, Board Administrator, reported that Dr. Alvin Thompson, a past member of the board, has passed away.

Boardmember Conlin made remarks about Dr. Thompson.

15. Other Business

16. Adjournment

The meeting was adjourned at 3:24 p.m.

Approved this _____ day of _____.

Clerk's Signature

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1200 King County Courthouse
516 Third Avenue
Seattle, WA 98104

KING COUNTY

Signature Report

September 12, 2012

Resolution

Proposed No. 12-09.1 **Sponsors**

A RESOLUTION commending Seattle Children's launch of Mission: Nutrition, an initiative that supports Seattle Children's efforts to be a healthy organization for its patients, families, visitors and staff.

WHEREAS, September is National Childhood Obesity Awareness Month, which was established as a time to take action to meet the national goal of solving the problem of childhood obesity within a generation, and

WHEREAS, one in five youth in King County is overweight or obese, and

WHEREAS, the consumption of sodas and other sugary drinks has been linked to risks for obesity, diabetes, heart disease, stroke and hypertension, and

WHEREAS, similar to rates seen nationally, thirty-one percent of King County high school students - or twenty-six thousand youth - report drinking at least one regular (non-diet) soda daily. Eight thousand of these students are drinking two or more sodas daily. A teenager who drinks two twenty-ounce regular colas per day consumes 4.7 cups of sugar per week - or two hundred and forty-three cups of sugar per year - from soda alone, and

WHEREAS, reducing sugary drink consumption has emerged as a key strategy for improving health, and

WHEREAS, Seattle Children's believes that all children have unique needs and should grow up without illness or injury, and

WHEREAS, Seattle Children's has recently launched Mission: Nutrition, a program designed to offer healthier food and drink options in its cafeterias, gift shop and vending machines. As part of Mission: Nutrition, Seattle Children's will remove sugar-sweetened drinks that have more than ten calories per eight ounce serving. This includes regular sodas, sweetened tea and coffee drinks, lemonade, sugar-sweetened fruit drinks, sports and energy drinks and flavored whole and two-percent milk.

WHEREAS, Seattle Children's beverage standards were informed by the King County Healthy Vending Guidelines, which were adopted by the Board of Health in 2011 as a tool that organizations can use to increase access to healthy food and drinks in vending machines, and

WHEREAS, Mission: Nutrition fits perfectly with Seattle Children's mission to prevent, treat and eliminate pediatric disease like obesity;

NOW, THEREFORE, BE IT RESOLVED BY THE BOARD OF HEALTH OF KING COUNTY:

The Board of Health commends Seattle Children's for its commitment to

preventing childhood obesity through its launch of Mission: Nutrition and for being a leader in the adoption of healthy workplace policies.

BOARD OF HEALTH
KING COUNTY, WASHINGTON

_____

Joe McDermott, Chair

ATTEST:

_____

Anne Noris, Clerk of the Board

Attachments: None

King County

King County Board of Health

Staff Report

Agenda item No: 7
Resolution No: 12-09

Date: September 20, 2012
Prepared by: Anne Pearson

Subject

A RESOLUTION commending Seattle Children's launch of Mission: Nutrition, an initiative that supports Seattle Children's efforts to be a healthy organization for its patients, families, visitors and staff.

Summary

This month, Seattle Children's Hospital launched Mission: Nutrition - a new initiative aimed at improving the nutritional quality of the food and drinks served at all Seattle Children's properties. A key component of Mission: Nutrition is the removal of all sugar-sweetened beverages in cafeterias, vending machines and gift shops.

Seattle Children's new beverage policy was informed by the King County Healthy Vending Guidelines, which were adopted by the Board of Health in 2011. It was also informed by a survey of patients, families, staff and visitors who voiced strong support for making healthy options more available, especially in hospitals.

Food environments have an enormous impact on the choices people make. By launching Mission: Nutrition, Children's is modeling the policies, environments and behaviors that promote the health of the children and families they serve.

Background

Sugary drinks are the largest single source of calories in the U.S. diet and account for almost half of all added sugars that Americans consume. Similar to rates seen nationally, consumption of sugary drinks by King County youth is high. For example, according to a new report:

- 31% of King County high school students - or 26,000 youth - drink soda daily.
- Approximately 8,000 King County high school students drink two or more sodas per day. (A person who drinks two 20-ounce regular colas per day consumes 4.7 cups of sugar per week -- or 243 cups of sugar per year -- from soda alone.)

- 2 out of 3 King County middle and high school students report drinking sugary drinks, including sodas, sports drinks or other flavored sweetened drinks, at school.

The consumption of sugary drinks has been linked to risks for obesity, diabetes, heart disease, stroke, and hypertension. Because one in five youth in King County is overweight or obese, reducing the amount of sugary drinks young people consume is a key strategy for improving health.

According to the Centers for Disease Control and Prevention, a key strategy for reducing consumption of sugary drinks is to limit their availability in homes, schools, worksites and communities. Research has shown that when access to sugary drinks is reduced, consumption goes down. For example, a recent study found that a rule limiting the availability of sugary drinks in Boston's school district reduced students' consumption of sugary drinks and doubled the number of kids who didn't drink any sugary drinks at all.

Analysis

By adopting nutrition standards for the beverages it serves on-site, Seattle Children's has demonstrated that it is a leader not only in the provision of health care services to patients, but also the establishment of environments that promotes health. Seattle Children's adoption of Mission: Nutrition has the potential to inspire other institutions across King County to explore what they can do to provide their employees, clients, customers and partners with health food and beverage options.

Attachments

1. Resolution 12-09
2. Public Health Data Watch: Youth Consumption of Sugary Drinks in King County
3. 10 Things Parents Should Know About Sugary Drinks
4. 10 Things Families & Organizations Can Do to Cut Down on Sugary Drinks

DATA WATCH

Public Health
Seattle & King County

SEPTEMBER 2012

YOUTH CONSUMPTION OF SUGARY DRINKS IN KING COUNTY

- **31% of King County high school students - or 26,000 youth - drink soda daily.**
- **Approximately 8,000 King County high school students drink two or more sodas per day.**
- **2 out of 3 King County middle and high school students report drinking sugary drinks, including sodas, sports drinks or other flavored sweetened drinks, at school.**

What are sugary drinks?

Sugary drinks are beverages with added sugars, such as regular sodas (or "pop"), energy drinks, sports drinks, sweetened fruit drinks, and sweetened coffees and teas. On average, a 20-ounce bottle of regular soda has more than 16 teaspoons of sugar and 240 calories. This is double the total amount of added sugar allowed for an entire day based on a 2,000 calorie diet.

Reducing sugary drink consumption is a key strategy for improving health

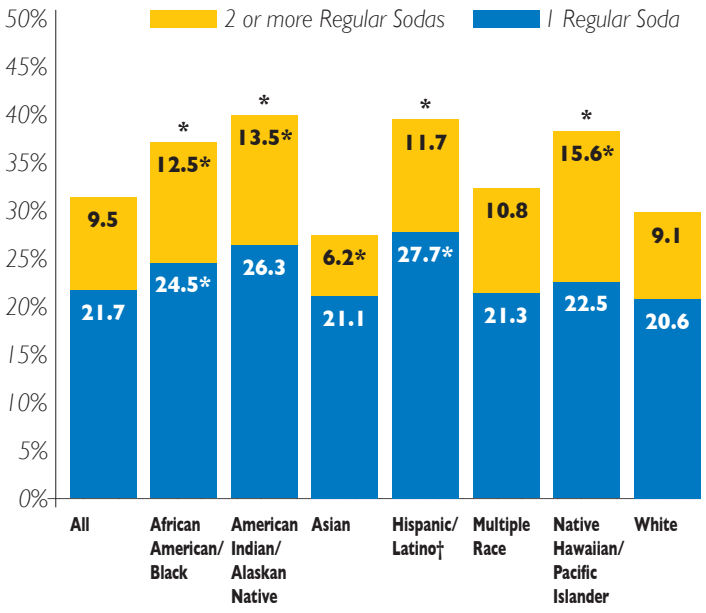
Sugary drinks are the largest single source of calories in the U.S. diet and account for almost half of all added sugars that Americans consume.[1, 2, 3] The consumption of sugary drinks has been linked to risks for obesity, diabetes, heart disease, stroke, and hypertension.[4, 5, 6, 7, 8] Because one in five youth in King County is overweight or obese, reducing the amount of sugary drinks young people consume is a key strategy for improving health.

For thousands of local youth, soda is part of daily diet

- Similar to rates seen nationally, 31% of King County high school students – or 26,000 youth – report drinking at least one regular (non-diet) soda daily. These numbers reflect only soda consumption – they do not capture the growing number of sports drinks, fruit drinks, vitamin waters and energy drinks that are increasing in popularity.
- Of the 26,000 King County high school students who drink soda daily, about 8,000 students are drinking two or more sodas. A teenager who drinks two 20-ounce regular colas per day consumes 4.7 cups of sugar per week – or 243 cups of sugar per year – from soda alone.
- Among high school students, daily consumption of at least one soda is highest among American Indian/Alaskan Native youth (40%), Hispanic/Latino youth (39%), Native Hawaiian/Pacific Islander youth (38%) and African American youth (37%) versus 30% for white, non-Hispanic youth (Figure 1).
- Consumption prevalence for Asians and whites is very similar, but higher numbers of white students drink two or more sodas daily. Multiracial students have similar consumption patterns to white, non-Hispanic students.

Figure 1:

Percent of High School Youth Consuming Regular Soda on Previous Day – King County (2010)



Data source: Washington State Healthy Youth Survey, 2010

†Hispanic/Latino considered as a separate group and not included in any other group

**Statistically significantly different from white, non-Hispanic students*

Produced by Public Health —Seattle & King County, Assessment, Policy Development & Evaluation Unit, 08/2012

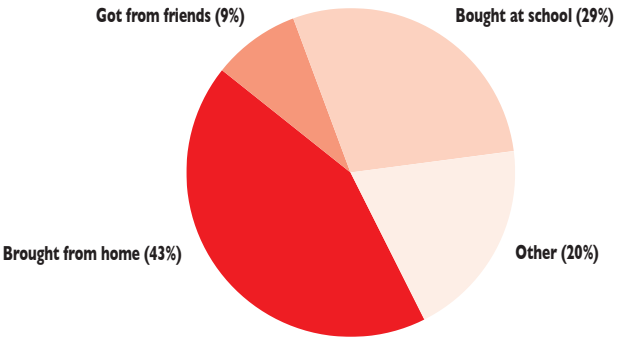
- Among high school youth, daily consumption of two or more sodas is highest among Native Hawaiian/Pacific Islander students (16%), and significantly higher than the 9% rate among white, non-Hispanic students. In addition, daily consumption of two or more sodas is twice as high among male students (14%) compared to female students (7%).
- Daily consumption of at least two sodas is higher among obese youth (15%) compared to healthy weight youth (9%) in grades 8, 10 and 12. One in five youth in King County is overweight or obese.[9]

Two thirds of youth have sugary drinks at school

- Nearly two thirds (65%) of middle and high school students report having consumed regular sodas, sports drinks or other flavored sweetened drinks at least one time in the past week at school.
- Of those youth who drink sugary drinks at school, 43% bring them from home, 9% get them from friends, 29% buy them at school, and 20% obtain them in other ways (Figure 2).
- 17% of male students, as compared to 8% of female students, report drinking 7 or more sugary drinks at school in a given week.

Figure 2:

Source of Sugary Drinks Consumed by Youth at School* – King County (2010)



Data Source: Washington State Healthy Youth Survey, 2010. Consumption does not total 100% due to rounding.

**Includes after school and weekend activities at school (grades 8, 10, 12)*

Produced by: Public Health - Seattle & King County, Assessment, Policy Development & Evaluation Unit, 08/2012

Sugary drinks and children's health

For children and youth, an increase of one serving of sugary drinks per day increases the odds of being obese by 60%.[10] As a result of obesity, today's children may have a shorter life expectancy than their parents.[11] Obesity is a major risk factor for diabetes; a third of all children born in the U.S. in 2000 are expected to develop diabetes. For Hispanic and African-American children, as many as half will do so.[12] Consumption of sugary drinks by young children has also been associated with an 80-120% increased risk of cavities.[13, 14]

Learn more about sugary drinks

Public Health - Seattle & King County
www.kingcounty.gov/health/sugarydrinks

Centers for Disease Control and Prevention (CDC)
www.cdc.gov/healthyweight/healthyeating/drinks.html

Yale University's Rudd Center for Food Policy & Obesity
www.yaleruddcenter.org

Center for Science in the Public Interest
www.cspinet.org

Kick the Can - Giving the Boot to Sugary Drinks
www.kickthecan.info

Soda Free Sundays
www.sodafreesundays.org

Data sources and references

Local youth sugary drink consumption data are from the Washington State Healthy Youth Survey, a school-based survey conducted every two years to measure adolescent health risk behaviors. Washington public schools, except institutional/correctional schools, serving grades 6, 8, 10 or 12 are eligible to participate. Estimate for grades 9-12 is derived from data collected in grades 8, 10 and 12.

For references, see: www.kingcounty.gov/healthservices/health/data/datawatch/Volume1103.aspx

This issue of Public Health Data Watch was produced by the Assessment, Policy Development & Evaluation Unit in collaboration with the Prevention Division. For more information and updates, contact data.request@kingcounty.gov and visit www.kingcounty.gov/healthservices/health/data.aspx, where you can subscribe to e-alerts to receive future Data Watches and other reports and announcements.

10 Things Parents Should Know About Sugary Drinks

Public Health
Seattle & King County

1. What are sugary drinks?

Sugary drinks are beverages with added sugars, such as non-diet sodas (or "pop"), energy drinks, sports drinks, sweetened fruit drinks, and sweetened coffees and teas.

2. How much sugar do they really have?

On average, a 20-ounce bottle of soda has more than 16 teaspoons of sugar and 240 calories. This is double the total amount of added sugar allowed for an entire day based on a 2,000 calorie diet.

3. What about sports drinks and energy drinks?

Energy drinks and sports drinks make up a growing part of the beverage market, and can contain as much sugar as soda. In a clinical report, the American Academy of Pediatrics concluded that energy drinks should never be consumed by children or adolescents and routine consumption of sports drinks should be avoided.

4. How many sugary drinks are our kids drinking?

In King County, nearly one in three high school students drink soda daily, and about 8,000 high school students drink two or more sodas per day. These numbers don't include the growing number of sports drinks, fruit drinks, vitamin waters and energy drinks that are so popular among kids.

5. If my child drinks two 20-ounce sodas per day, how much sugar is he drinking?

A person who drinks two 20-ounce regular colas per day consumes 4.7 cups of sugar per week — or 243 cups of sugar per year — from soda alone.

6. Do sugary drinks harm kids' teeth?

Consumption of sugary drinks by young children under the age of 5 is associated with an 80-120% increased risk of cavities. Consumption of energy drinks and sports drinks, which are highly acidic, irreversibly damages teeth through the erosion of tooth enamel.

7. What are the other health effects of drinking too many sugary drinks?

The consumption of sugary drinks has been linked to risks for obesity, diabetes, heart disease, stroke, hypertension and cavities. For children and youth, an increase of one serving of sugary drinks per day increases the odds of being obese by 60%.

8. Is obesity a problem in King County?

In King County, one in five children in middle and high school are overweight or obese, and over half of King County adults are either overweight or obese. These rates are even higher in low income communities and communities of color.

9. Is it ok for my kids to have diet sodas?

Although diet beverages can provide calorie savings if substituted for high-calorie sugary drinks, they often have high acid content that can harm teeth. And for children, they have the potential to displace milk and other healthier options, including water.

10. Why single out sugary drinks?

Sugary drinks are different from other foods in that they are consumed in massive quantities, have no nutritional value, and are clearly linked to obesity. Additionally, unlike other foods with sugar, sugary drinks don't make us feel full.

For more resources and the references for these facts, please visit: www.kingcounty.gov/health/sugarydrinks

10 Things Families & Organizations Can Do to Cut Down on Sugary Drinks

Public Health
Seattle & King County

Individuals & families


Image: FreeDigitalPhotos.net

1 Purchase, serve and enjoy low-sugar options like water, low-fat milk, unsweetened tea and coffee drinks, and small portions (4 ounces or less) of 100% fruit juice.

2 Be creative! Ask your kids to design their own fun beverages for special occasions using carbonated water, fresh fruit and 100% fruit juice.

3 Send your kids off to school with a cold thermos of water.

4 Help your kids get the sleep they need by ensuring that everything they drink is caffeine-free.

5 If you do have a sugary drink as an occasional treat, cut calories and save money by ordering a small size and saying "no thanks!" to refills.

Employers, organizations, schools & public places

6 Ensure easy access to cool, fresh water at work, in organizations that serve kids and in public spaces.

7 Use marketing and pricing strategies to promote healthy items. Stock healthy beverages at eye-level and price them to move!

8 Keep portion sizes reasonable by eliminating super-sized sugar drinks.

9 Use the King County Healthy Vending Guidelines to make sure that your vending machines offer the healthiest beverage options.

10 Adopt a healthy beverage policy that clearly states the types of drinks that can be sold or made available in your workplace or organization. Include your employees and key stakeholders (such as members, customers or managers) in the development of the policy. They'll thank you for it!

For more resources and the references for these facts, please visit: www.kingcounty.gov/health/sugarydrinks

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King County

1200 King County Courthouse
516 Third Avenue
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KING COUNTY

Signature Report

September 12, 2012

Resolution

Proposed No. 12-10.1 **Sponsors**

A RESOLUTION calling on the Washington state Legislature to restore local control of retail tobacco sales and promotion.

WHEREAS, tobacco use is the most preventable cause of premature death, disability and disease in the United States, and

WHEREAS, annually, an estimated four hundred forty-three thousand people nationwide, seven thousand six hundred people in Washington state and one thousand eight hundred people in King County die prematurely from smoking or exposure to secondhand smoke, and

WHEREAS, Washington's Youth Access Law preempts local governments from adopting or enforcing regulations related to retail tobacco sales and promotion, and

WHEREAS, local governments have the right and responsibility to adopt laws that protect the health and safety of their citizens, and

WHEREAS, the needs of a specific community may be different from those of the state as a whole. Local policymakers live in the communities in which they serve, so they can be more responsive to public sentiment, and

WHEREAS, since implementation of the state's comprehensive Tobacco Prevention and Control Program, youth cigarette smoking declined dramatically from

1999 to 2004. In recent years, reductions in smoking rates have stalled despite media campaigns and price increases, and

WHEREAS, the Washington state Legislature eliminated all funding for the state's comprehensive Tobacco Prevention and Control Program, effective July 2011. As a result of this dramatic funding cut, the state no longer funds anti-tobacco media campaigns or local tobacco prevention and cessation programs in schools or through local governments and community organizations. The power to create tobacco prevention policy at the local level has the potential to reduce the risk that smoking rates increase as they have in other states after comprehensive programs disappear, and

WHEREAS, rates of youth smoking in Washington state are unacceptably high: about thirteen percent of 10th graders smoke cigarettes and fifty children start smoking every day, and

WHEREAS, tobacco companies spend an estimated $122.5 million each year to market products in Washington state and have recently introduced tobacco products that appeal to children because of their fruit and candy flavoring and colorful packaging, and

WHEREAS, more than fifteen thousand King County middle and high school students, including one in four 12th graders, used cigarettes or other tobacco products in the past month, and

WHEREAS, the tobacco epidemic in Washington state has different characteristics in different locations. A one-size-fits-all approach may not work in all cases, so communities need the ability to adopt approaches that work for their populations, and

WHEREAS, state laws that preempt local regulation of tobacco sales prevent local governments from enacting local laws that are tailored to meet the needs of their communities and have a devastating effect on tobacco control efforts and on the public health of the state's residents and workers, and

WHEREAS, Congress has recognized the vital role that states and localities play in restricting youth access to tobacco products, and in June 2009 enacted legislation expressly permitting states and localities to regulate cigarette advertising and promotions, and

WHEREAS, the U.S. Department of Health and Human Services made the elimination of state laws that preempt stronger tobacco control laws a national goal in Healthy People 2020, and

WHEREAS, national organizations, such as American Cancer Society, American Heart Association, American Lung Association, American Public Health Association, Americans for Non-Smoker's Rights, Campaign for Tobacco Free Kids, Centers for Disease Control and Prevention, National Association of County and City Health Officials and National Association of Local Boards of Health, oppose state preemption of local tobacco control laws;

NOW, THEREFORE, BE IT RESOLVED that the Board of Health of King County:

A. The Board of Health calls upon the Washington state Legislature to repeal preemption in the state's youth access to tobacco law, chapter 70.155 RCW, and restore the right of local governments to enact and enforce tobacco-related laws.

B. The Board of Health of King County strongly encourages other local boards of health in Washington to adopt similar resolutions.

BOARD OF HEALTH
KING COUNTY, WASHINGTON

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Joe McDermott, Chair

ATTEST:

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Anne Noris, Clerk of the Board

Attachments: None

King County

King County Board of Health

Staff Report

Agenda item No: 8
Resolution No: 12-10

Date: September 20, 2012
Prepared by: Joy Gilroy, MPH
Project Manager, Washington State Association of Local Public Health Officials

Subject

A RESOLUTION calling on the Washington State Legislature to restore local control of retail tobacco sales and promotions.

Summary

The proposed resolution calls on the Washington State Legislature to amend the Youth Access to Tobacco law (RCW 70.155.130) by removing the preemption clause and adding anti-preemption language. With preemption removed, local governments will be able to create and enact local tobacco policies that are tailored to protect their constituents' health.

Background & Analysis

While the federal government plays a critical role in public health, state and local governments have often protected health and safety more aggressively than Congress or federal regulators.[i,ii] In the words of Assistant Secretary of Health Howard Koh, "all public health is local - it's got to start and be sustained at the local level."[iii] Preemption shifts jurisdiction over tobacco from the local level to the state or federal level where the tobacco industry has greater influence in policy development and shifts regulatory authority away from localities. When preemption was recognized as a strategy of the tobacco industry to exercise greater influence over government regulation in the late 1990s, all of the major health and tobacco control organizations made statements opposing preemption[iv] and more recently the U.S. Department of Health and Human Services has made the elimination of state laws that preempt stronger tobacco control laws a national goal in Healthy People 2020.[v] There are 22 states with laws preempting local restrictions on youth access and none have been successful in repealing preemption. The Institute of Medicine has stated that state policy makers "should set minimum standards… allowing localities to further protect the health and safety of their inhabitants."[vi]

Localities in Washington state, such as counties and cities, had the authority to create local tobacco policies until 1993 when the Youth Access to Tobacco Law was enacted by the state legislature in 1993, preempting that authority. Prior to 1993, communities like King County

were considering and creating local tobacco policies such as prohibiting tobacco sampling. In the 20 years since, several laws have been proposed that would repeal the preemption component of the Youth Access to Tobacco Law but none have been successful. In 1997, the King County Board of Health adopted a resolution in support of preemption repeal.

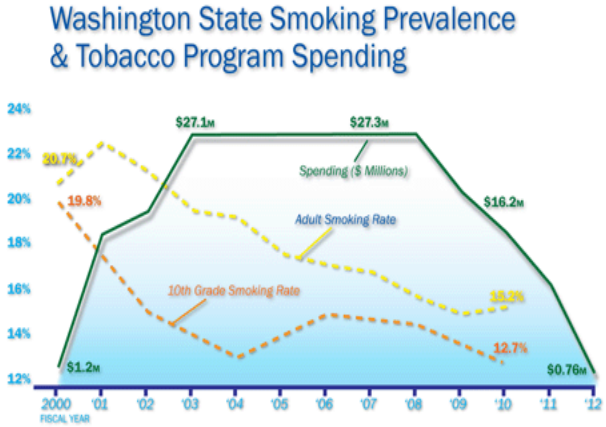
Benefits of Local Control

Local control is a powerful tool that allows communities to find regulatory solutions appropriate to their local areas. For example, one community that has high youth tobacco use rates might opt to prevent kids from accessing tobacco by requiring that all tobacco products be sold behind the counter where theft is less likely. Another community might address a similar problem by restricting the location of tobacco retailers near schools. Local control gives communities the choice on how they want to respond to their local issues. Local control also allows for policies to be tested and refined before becoming or influencing statewide policy. Tobacco policies such as clean indoor air laws have historically been adopted and tested at the local level before becoming state law.

Providing greater local control could help ensure that we can protect our kids and our communities from new, addictive and lethal products. As the tobacco industry continues to develop new products such as the dissolvable, breath-strip-like tobacco products that were test marketed in Portland, local control could provide a mechanism to protect the communities from becoming the next test market. It also gives communities a means to assess innovative ways of curbing tobacco use that might later be implemented across the state.

Why is the time right to return local control over tobacco to communities?

Funding has been cut Over the past several years, the Washington State Legislature greatly reduced all funding for comprehensive tobacco prevention and control programs from over $27 million to only $750,000 on tobacco prevention efforts in fiscal year 2012. These funds will be spent on compliance checks and retailer education. Also in fiscal year 2012, the state will spend about $1.9 million to cover tobacco cessation Quitline treatment for Medicaid enrollees. As a result of the dramatic funding cut, Washington will no longer fund anti-tobacco media campaigns or local tobacco prevention and cessation programs in schools or through local governments or community organizations.



Build on momentum In the 2011 state legislative session, bills were introduced that would give local jurisdictions control over tobacco regulation. In the House, the bill had bi-partisan sponsorship and passed out of the Committee on Health Care and Wellness, but in the Senate the bill had a hearing in the Senate Committee on Labor and Commerce & Consumer Protection but was not voted on. Continued efforts to educate the public and legislators are needed to help raise awareness about tobacco issues.

New authority to make regulations For many years, the Federal Cigarette Labeling and Advertising Act preempted states from taking any action, for health purposes, to restrict cigarette advertising or promotion. However, the Family Smoking Prevention and Tobacco Control Act, signed into law June 22, 2009 and in effect as of June 22, 2010, now allows states or local communities to restrict or regulate the time, place and manner (but not the content) of any cigarette advertising or promotions.

50 youth a day in Washington start using tobacco The rate of youth who use tobacco has not declined in recent years and rates of alternative tobacco products (like hookah and little cigars) are rising. When funding has been cut in other states, youth smoking rates have gone back up and it is likely that will happen in Washington as well.

Tobacco industry marketing to youth The tobacco industry is creating new tobacco products with flavors and bright packaging that appeal to kids. The tobacco industry knows that kids are a key market to recruit lifelong customers; approximately 90% of current adult tobacco users started using tobacco before they were 18 years old.

Attachments

1. Resolution No. 12-10

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[i] Obama, B. Memorandum for the Heads of Executive Departments and Agencies, Office of the Press Secretary, The White House, 2009 WL 1398319 (May 20, 2009). Available at: http://www.whitehouse.gov/the_press_office/Presidential-Memorandum-Regarding-Preemption/. Accessed May 10, 2011.

[ii] Pomeranz JL. The Unique Authority of State and Local Health Departments to Address Obesity. Am J Public Health. 2011;101(7):1192-1197.

[iii] Koh H. Weight of the Nation: CDC's Inaugural Conference on Obesity Prevention and Control. Washington, DC; July 28, 2009. Available at: www.adph.org/ALPHTN/index.asp?id=3775. Accessed May 10, 2011

[iv] Hobart R. *Preemption: Taking the Local Out of Tobacco Control.* American Medical Association; updated 2003. http://www.rwjf.org/newsroom/SLSPreemption2003.pdf. Accessed March 26, 2012.

[v] Healthy People.gov Website: Tobacco Use. http://healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=41. Accessed March 26, 2012.

[vi] IOM (Institute of Medicine). For the Public's Health: Revitalizing Law and Policy to Meet New Challenges. Washington, DC: The National Academies Press, 2011.

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1200 King County Courthouse
516 Third Avenue
Seattle, WA 98104

KING COUNTY

Signature Report

September 13, 2012

Resolution

Proposed No. 12-11.1 **Sponsors**

A RESOLUTION calling on the Drug Enforcement Administration to expedite its efforts to provide our communities with additional options for operation of secure, accessible, convenient medicine take-back programs that can safely dispose of all household medications, including controlled substances.

WHEREAS, more people die from prescription medicines than from all illegal drugs combined, and

WHEREAS, studies have shown that prescription medicines are the first drugs that many people abuse, and most are obtained from family and friends, including from home medicine cabinets, and

WHEREAS, medicines used in the home are the leading cause of poisonings reported to the Washington Poison Center, and preventable poisonings from medicines have been rising rapidly, especially among children and seniors, and

WHEREAS, drug overdoses in Washington have surpassed car crashes as the leading cause of preventable deaths, with the majority of overdoses involving prescription opiates, and

WHEREAS, the White House Office of National Drug Control Policy recommends four elements for the prevention of prescription drug abuse in its 2012 National Drug Control Strategy:

1. Educating prescribers, parents and patients;

2. Increasing the number of prescription drug monitoring programs and improving their effectiveness;

3. Encouraging and providing for the proper disposal of prescription drugs; and

4. Increasing enforcement against illicit pill mills, doctor shopping and prescribing that is not in keeping with standard medical practices, and

WHEREAS, the White House Office of National Drug Control Policy, the Drug Enforcement Administration, the Food and Drug Administration and the Environmental Protection Administration, as well as King County, Seattle and other local agencies, recommend medicine take-back programs as a more secure and environmentally safe disposal method than throwing medicines in the trash, and

WHEREAS, nine city police stations, twelve Bartell Drug retail pharmacies and twelve Group Health clinical pharmacies in King County currently offer medicine take-back and use approved security protocols to prevent diversion, but the county lacks a comprehensive and convenient medicine take-back system, and

WHEREAS, current federal regulations reduce the accessibility and convenience of medicine take-back programs by requiring that prescription drugs that are controlled substances, such as narcotics and stimulants, can only be returned to law enforcement officers, not to pharmacies, and

WHEREAS, two years ago, in October 2010, federal law was amended by the Secure and Responsible Drug Disposal Act authorizing the Drug Enforcement Administration to promulgate new regulations providing additional convenient and cost-effective options for the disposal of controlled substances dispensed to patients, and

WHEREAS, local law enforcement, pharmacies, health professionals, community organizations and residents of King County are eager for the release of the Drug Enforcement Administration's new regulations for collection of controlled substances to enhance the efficiency, effectiveness and access of community medicine take-back programs, and

WHEREAS, to help protect public safety while developing those new regulations, the Drug Enforcement Administration has coordinated semi-annual National Prescription Drug Take-back Days with local law enforcement, which have removed over 1.5 million pounds, or seven hundred seventy-four tons, of medications from circulation nationwide, and over eight thousand pounds in King County, showing a desire by individuals to safely dispose of their leftover medications;

NOW, THEREFORE, BE IT RESOLVED by the Board of Health of King County:

The Board of Health calls on the Drug Enforcement Administration to expedite the release and adoption of regulations under the Secure and Responsible Drug Disposal Act of 2010 to provide our communities with additional options for collection of

prescription drugs that are regulated as controlled substances by secure medicine take-back programs.

BOARD OF HEALTH
KING COUNTY, WASHINGTON

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Joe McDermott, Chair

ATTEST:

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Anne Noris, Clerk of the Board

Attachments: None

King County

King County Board of Health

Staff Report

Agenda item No: 9
Resolution No: 12-11

Date: September 20, 2012
Prepared by: Maria Wood, Margaret Shield

Subject

A Resolution calling on the Drug Enforcement Administration to expedite its efforts to provide additional options for operation of secure, accessible, convenient medicine take-back programs that can safely dispose of all household medications, including controlled substances.

Summary & Analysis

The misuse of prescription drugs has emerged as a national epidemic over the last decade. Amounts of prescription drugs dispensed have increased overall; in particular, the quantity of prescription painkillers sold to pharmacies, hospitals, and doctors' offices in 2010 has quadrupled since 1999. With the rise in the amount of prescription drugs available has come an increase in the number of drug-related fatalities as well as non-fatal poisonings —nationally and here in King County. Large amounts of prescription and over-the-counter medicines go unused for a variety of reasons. In the 2011 action agenda "Epidemic: Responding to America's Prescription Drug Abuse Crisis," federal agencies issued a call for action in four major areas: (1) education of providers and the community, (2) prescription drug monitoring programs, 3) consumer friendly and environmentally-responsible drug disposal, and (4) enforcement to shut down "pill mills" and "doctor shopping." Efforts are underway in Washington State on three of these recommendations. Education programs for providers and the community are underway, and a 2010 Washington law established new rules for practitioners on prescribing and management for chronic pain patients. Prescription drug monitoring is already the law and the program launched in October 2011. Enforcement actions to stop "pill mills" and improper prescribing are ongoing.

Under the federal Controlled Substances Act, the Drug Enforcement Administration closely regulates the distribution of prescription drugs that are legally prescribed controlled substances, such as OxyContin, Vicodin, and Ritalin. About 11% of prescription drugs dispensed are legally prescribed controlled substances. Drug Enforcement Administration regulations do not allow patients to return unused quantities of controlled substances to the dispensing pharmacy or prescribing doctor. Currently, these controlled drugs can only be legally collected by law enforcement, not by pharmacies or any other entities.

This complication in federal law is being remedied. In October 2010, the "Secure and Responsible Drug Disposal Act" was passed to amend Controlled Substances Act to facilitate the

collection of controlled drugs by medicine return programs. Back in May 2009, the Board of Health set a letter to Congressman Jay Inslee stating support for this federal legislation. While the law does not mandate creation of medicine take-back programs or provide any funding, it authorizes the Drug Enforcement Administration to promulgate regulations that will authorize new options for collection of controlled drugs without participation of law enforcement. The draft regulations are anticipated before the end of 2012. While working on rule-making since fall 2010, and due to the tremendous need for drug take-back, the Drug Enforcement Administration has been offering limited assistance to local law enforcement to provide semi-annual National Pharmaceutical Take-Back one-day events. The DEA plans to stop coordinating these take-back days once the new regulations for collection of controlled drugs are finalized.

The Board of Health has supported the creation of safe medicine take-back programs as part of a comprehensive strategy to reduce the epidemic of overdoses, misuse, and preventable poisonings from medications, and to reduce environmental pollution from waste pharmaceuticals. The Board of Health has received briefings from the Local Hazardous Waste Management Program (LHWMP) on the status of medicine take-back initiatives in the past and taken actions to support creation of secure medicine take-back systems at the state level. A subcommittee has been convened to further study the issue and has held three meetings with a primary focus of listening to stakeholders about the need for a local take-back program.

Passage of the "Secure and Responsible Drug Disposal Act" was a significant step toward making take-back programs more accessible for the community. Completion of the DEA rule making process will provide additional options for operation of secure, accessible, convenient medicine take-back programs that can safely dispose of controlled substances along with all other household medications. Through this proposed resolution, the King County Board of Health conveys the community's support and demand for an efficient, effective, and accessible community medicine take-back programs.

Attachments

1. Resolution No. 12-11

King County

King County Board of Health

Staff Report

Agenda item No:	10	Date:	September 20, 2012
BOH Briefing No:	12-B13	Prepared by:	Maria Carlos, TJ Cosgrove

Subject

A briefing on the intersection of public health programs that focus on healthy development and healthy living and an education initiative that impact the success of young people from cradle to college and career.

Summary

This briefing will orient the Board of Health to the work of the Community Center for Education Results (CCER) and Public Health – Seattle & King County's services and strategies that link to and impact both health and educational outcomes.

CCER supports the Road Map Project, a community-wide effort aimed at advancing education to drive dramatic improvement in student achievement from cradle to college and career in south King County and south Seattle. The project builds off of the belief that collective effort is necessary to make large-scale change and has created a common goal and shared vision in order to facilitate coordinated action, both inside and outside school. The Road Map Project has included key health indicators in the data that are monitored to measure the success of the project. These measures include but are not limited to healthy birth weight, Healthy Youth Survey data, and teen birth rates. The Road Map Project tracks measures from cradle to college and career and evaluates disparities across populations.

Public Health services and strategies are aligned with this approach - working toward the goal of improving health throughout the life course and impacting the ability of children to learn, graduate on time, and lead full, productive lives. Public Health efforts that include this life-course orientation and bridge impacts on health and education include Community Health Services programs such as: parent-child health programs like Nurse Family Partnership, WIC and Maternity Support Services; Child Care Health; school-based health programs including school based health centers; and family planning programs. Public Health's Prevention Division has five units within the Chronic Disease and Injury Prevention Section that all do work that impact the health of school aged children in King County, including Healthy Eating & Active Living, King County Asthma Program, Tobacco Prevention & Control Program, Violence & Injury Prevention Program, and Women's Health. Our Communicable Disease Section also works to ensure all children are immunized. These programs work to improve the policies,

systems, and environments that impact all populations in King County, especially those with the highest health disparities, using information such as the health indicators listed here and community assessment. For example, one in five middle and high school students in King County is overweight or obese, so one focus of our efforts is to increase access to healthy foods and physical activity.

The measures of success in these efforts overlap with the Road Map project and share the critical function of eliminating the inequities that certain populations experience.

Background & Analysis

Health and education are closely linked. Healthy students learn better and educated people are more likely to be healthy. The communities and populations that experience disparities in health outcomes greatly overlap with the communities and populations that are negatively impacted by the academic achievement gap. For instance, 58.7% of American Indian/Alaska Native, 63.9% of Latino, and 71% of African American students graduate on time, compared to 82.7% of all King County students. Students of color experience higher percentages of health risk factors that impact graduation, including lack of access to healthy food and exercise, and higher incidence of depression. There is a logical alignment between efforts in Public Health to provide services and foster healthy choices and efforts in education to prepare school age children to learn, graduate on time and enter career or college prepared for productive lives.

A complex interplay of biological, behavioral, psychological, and social protective and risk factors contributes to health outcomes across the span of a person's life. Prevention and supportive strategies throughout every stage of life – from pre-conception through adulthood – will improve long-term health and life outcomes.

Socioeconomic status, race and racism, neighborhood conditions, health care, disease status, stress, nutrition and weight status, birth weight, and a range of behaviors are some of the key protective and risk factors that may affect health and education outcomes. These factors, in both the past and the present, may affect people of various ethnic groups differently. Understanding this "Lifecourse" perspective creates opportunities to build upon protective factors and reduce risk factors. In this context, public health programs and strategies focus on building environments that support equitable, healthy, and thriving communities, and ensuring that the broad array of protective and risk factors are addressed in an integrated, coordinated, and comprehensive manner.

Education advocates take a similar approach, focusing on improving protective factors to achieve improved education and life outcomes, from cradle to career. The Road Map Project, supported by the Community Center for Education Results, is a collective impact initiative aimed at improving student achievement throughout a child's life. The program seeks to align actions within and outside of the education system, focusing on providing strong data, engaging parents and communities, and aligning funding to achieve solid outcomes.

Health risk factors such as obesity, poor nutrition, feeling unsafe at school, experiencing depression, or using drugs and alcohol increase students' academic risk. Further, research shows that exposure to Adverse Childhood Experiences (ACEs) also increases academic risk as well as health risks. Increased academic risk influences students' ability to graduate on time, thereby influencing their ability to lead full, healthy, productive lives. For instance, the Healthy Youth Survey shows the percentage of students in King County experiencing twelve specific health risks. The more health risks, the more likely these students will experience academic risk, which is defined as "usually getting C's, D's, or F's in school". This trend holds true for students across the County as well as for students in the Road Map Region.

The Washington Office of the Superintendent of Public Instruction data show that on-time graduation in King County depends on where the student lives and varies by race/ethnicity. Students in south King County school districts experience lower percentages of on-time graduation than other areas of the County, which is why the Road Map Project is focused on those school districts. These are districts have a higher percentage of low-income families and families of color than other areas of the County. In that region, over half (54%) of the students come from families of low income, and 60% are students of color. One hundred sixty-seven different primary languages are spoken in that area of King County.

Similarly, we know that the health status of and outcomes for individuals depend on where people live and that the disparities in health overlap with those in education. Public Health services and strategies address child and family health in these communities and populations, addressing children's health across life stages to improve their long-term health and life outcomes. Programs for children before they enter schoolwork toward a goal of helping children be healthy and ready for school. Elementary school based health programs ensure students are supported and successful in school by improving their access to early and regular health care. They ensure elementary age children have access to early screening, assessment and referral to interventions that improve their physical and mental health. Middle and high school based health centers contribute to improving youths' health and academic outcomes so that all students have the chance to graduate college and/or career ready, on time. Particular attention is paid to students' health status/concerns as well attendance and barriers to succeeding in all classes. The Tobacco Prevention and Control and Violence and Injury Prevention Programs contribute towards environmental and policy measures that will improve school-age children's health. The Healthy Eating & Active Living Program works on Nutritional and Physical Activity standards for child care and schools.

The Road Map Project engages parents and communities to examine the data on academic, health and other indicators of children's success across their life stages. The Road Map Project works with these communities to identify actions that will improve the system of academic and other community services to improve children's outcomes, and achieve school success, so that they will lead full, productive lives. Public Health is a partner in these efforts to make a collective impact on the disparities in health and education.

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King County

King County Board of Health

Staff Report

Agenda item No: 11
BOH Briefing No: 12-B14

Date: September 20, 2012
Prepared by: Jennifer DeYoung

Subject

A briefing on recent and upcoming King County activities related to health reform planning.

Summary

In previous briefings to the Board of Health in March and July 2012, staff from Public Health-Seattle & King County and the Department of Community and Human Services spoke to health reform issues affecting King County and work being done in preparation and response. One forum in which Public Health-Seattle & King County and the Department of Community and Human Services are engaging health and social service safety net system representatives around this planning work is the King County Health Reform Planning Team. This summer, the Planning Team endorsed the *King County Framework for an Accountable, Integrated System of Care for Low-Income Residents,* which represents the group's vision for the establishment of an accountable system of care in King County that is effective in achieving the triple aim—improving the quality of care, reducing costs, and improving population health. This *Framework* is an important tool for informing our priorities around health reform, particularly during these next 18 months when many public programs are being reformed in anticipation of significant provisions of the Affordable Care Act going into effect. Using the *Framework* as a guiding tool, five areas have been identified as those where local action can have the greatest impact in improving in community health and recovery: (1) assuring access to health coverage, (2) assessing and monitoring the capacity of the health system, (3) driving delivery system integration, (4) adequacy of resources to achieve the *Framework* vision, and (5) continued education of the community on health reform impacts.

Background

Overview of the King County Health Reform Planning Team

Over the past year, staff from Public Health-Seattle & King County and the Department of Community and Human Services have provided two briefings to the Board of Health on health reform in King County:

- On March 15, 2012, staff delivered Briefing No. 12-B04 regarding near-term and longer-term health reform issues likely to affect the safety-net health care system in King County and the residents who rely on it.
- On July 19, 2012, staff delivered Briefing No. 12-B11 on the progress that has been made on several major elements of health reform at the national, state and local levels.

In both briefings, staff referenced the King County Health Reform Planning Team, co-convened by Public Health-Seattle & King County and the Department of Community and Human Services, as a forum for community dialogue and planning related to health reform in King County. This group of safety-net providers, payors, consumers, and other community leaders has come together for more than a year to discuss the deepening health inequities and rising cost of health care in King County and the opportunities presented under health reform to help address these issues.

Overview of the *Framework* Document

Recognizing the relationship between health status and the social and environmental conditions in which people live, the Health Reform Planning Team has articulated a vision for a King County safety-net health system that goes beyond the provision of health care services. This vision is laid out in a document called the *King County Framework for an Accountable, Integrated System of Care for Low-Income Residents*, which was endorsed by the Health Reform Planning Team in June 2012.

The concepts that underlie the *Framework* respond to the known challenges in the U.S. health system, including its unsustainable high costs and misaligned payment incentives that reward volume over quality. Across the nation, new models of care and payment reforms are emerging that simultaneously improve the quality of care, reduce costs, and improve population health—a concept known as the "triple aim."[1] It is increasingly recognized that successful transformation requires a conception of health that goes beyond the traditional, formal health care system, incorporating a much more expansive view of what care is, where it is delivered, and who delivers it. The *Framework* embraces these concepts, articulating an intent to shift toward a health system design that is effective in addressing the social determinants of health—both by working to improve integration of nonclinical services (such as housing, employment services, nutrition, and others), and by working at the policy level to improve community conditions in ways that tackle the fundamental link between poverty and poor health.

Included in the *Framework* is a description of the four core elements stakeholders agree are needed to achieve the vision of an accountable system of care that is effective in achieving the triple aim:

1. *Care will be organized around the individual in a way that best supports their health.* This element focuses on the creation of a comprehensive approach to organizing primary

[1] Institute for Healthcare Improvement: http://www.ihi.org/offerings/Initiatives/TripleAim/Pages/default.aspx

care through a person-centered medical home or health home that coordinates primary and specialty care, behavioral health services, health promotion, and chronic care management. Individuals will get the right care at the right time in the right place, in a culturally and linguistically appropriate manner.

2. *Robust system of care management for those with chronic health conditions.* This element describes the implementation of care coordination that works across service domains and disciplines for individuals with chronic health conditions, including mental health and substance abuse. Care management, including self-management support, will be organized in a systematic, rational way that prevents duplication and assures integration with the medical home.
3. *The delivery system will increasingly offer services through culturally appropriate community hubs organized around the needs of individuals.* This element describes the intent to create community hubs throughout the county that include integration of and rapid access to a wide range of services and supports, such as health services, insurance coverage, housing assistance, employment assistance, family support services, legal assistance, income assistance, basic needs, and crisis services, as well as serving as focal points for community wellness.
4. *A prevention, wellness, and recovery orientation will infuse the system of care as well as the community environment.* This element focuses on shifting from a system focused primarily on treating illness to one focused on preventing illness and promoting recovery and resiliency by providing prevention, wellness and recovery services in community settings and improving the conditions of our communities through policy and system change tools.

Application of the *Framework*

The *Framework* is a dynamic document that serves as a tool against which to evaluate our current health and human services system relative to where we want it to be, and to inform specific action priorities to achieve the vision of a transformed system of care. The next 18 months are a particularly critical window during which delivery system and payment reforms will be designed in public programs such as Medicaid and Medicare in anticipation of 2014, when some of the most significant provisions of the Affordable Care Act go into effect.

The following five areas have been identified as those where local leadership and action can most leverage improvements in community health and recovery, and they are now forming the basis for a next-step action plan. These priorities include: (1) assuring **access** to health coverage, including mental health and substance abuse treatment, especially among those expected to be eligible for Medicaid expansion; (2) assessing and monitoring the **capacity** of the health system—medical, mental health and substance abuse—against demand; (3) driving **delivery system integration** that brings together clinical care, health promotion and human services for greater collective impact on the health of King County; (4) adequacy of **resources** to achieve the Framework vision; and (5) continued **education** of residents, providers, and others to prepare for health reform impacts.

In some of these areas, actions are already underway. One example of application of the *Framework* currently in King County is the county's work on exploring participation in several State initiatives that would provide health systems with financial incentives to provide better management of individuals and populations, particularly those with chronic health conditions and poor health outcomes. Recently the King County Council approved a motion for the county to continue exploring potential participation in a State demonstration project to create a financially integrated care model for individuals eligible for both Medicare and Medicaid in which medical, mental health, substance abuse and long term care services would be purchased through a managed care organization. With careful and thoughtful implementation, this demonstration project stands to align with the elements of the *Framework,* and could successfully tear down the financing and delivery silos that have long been in existence, putting in place a well-coordinated and integrated model of care. As the County continues to evaluate over the next few months its possible participation in this demonstration project, the *Framework* will serve as a key guiding tool.

Analysis

Health reform under the Affordable Care Act presents great opportunities for King County to improve the deepening health inequities experienced by our population by applying the concepts of the triple aim—improving quality of care, reducing costs, and improving population health. Today, one out of every five King County residents—over 420,000 adults and children—lives below 200 percent of the federal poverty level. Relative to those with higher incomes, this group faces significant inequities in health, with high and rising levels of chronic illness such as heart disease, diabetes, and mental health and substance abuse disorders. Of particular concern is that this burden of poor health disproportionately affects racial and ethnic minority residents. The King County Health Reform Planning Team, which is made up of stakeholders from across the King County safety net community, presents a great opportunity for ensuring the benefits from health reform are realized in our community and the end result is better health and well-being for King County's low-income and underserved residents. The *King County Framework for an Accountable, Integrated System of Care for Low-Income Residents,* which articulates the Health Reform Planning Team's vision of an accountable system of care, serves as a guiding tool for prioritizing our local efforts so that we are effective in achieving the triple aim and reducing the health inequities experienced by low-income residents in King County.

Attachments

1. King County Framework for an Accountable, Integrated System of Care for Low-Income Residents
2. King County Health Reform Planning Team Vision

King County Framework for an Accountable, Integrated System of Care for Low-Income Residents

June 25, 2012

Background

In King County, the benefits of good health are not equally shared by all residents. Today, one out of every five King County residents – over 420,000 adults and children – lives below 200 percent of the federal poverty level. Relative to those with higher incomes, this group faces significant inequities in health, with high and rising levels of chronic illness such as heart disease, diabetes, and mental health and substance abuse disorders. Of particular concern is that this burden of poor health disproportionately affects racial and ethnic minority residents.

Adding to these health challenges, approximately 30 percent of those living below 200 percent of the federal poverty level are uninsured. Those who do have coverage often access it through public programs with limited benefits such as Medicaid, Medicare, and the Basic Health Plan. Community and public health centers, hospital systems, the long-term care system, mental health and substance abuse agencies, correctional health services, health plans, and housing and human service programs constitute the "safety net" health system that provides much of their care.

Spurred by deepening health inequities, the rising cost of health care, and the opportunities presented under health care reform, King County convened a group of safety net providers, payors, consumers, and other community leaders in 2011. Known as the King County Health Reform Planning Team, this group of stakeholders has been working toward an accountable, integrated system of care that drives better health and well-being for King County's low-income and underserved residents.

As health reform unfolds in Washington State and across the nation, King County has a unique opportunity to leverage new funding and reform designs to address the shortcomings in the current system. Over the next 18 months, the King County Health Reform Planning Team's leadership is critical to organizing the safety net delivery system to improve the system of care for the most vulnerable residents in the community.

Purpose of the Framework

This Framework lays out a vision for an accountable system of care that is effective in reducing health inequities experienced by low-income residents of King County, and describes the core elements that stakeholders agree are needed to achieve it. The Framework communicates the form of the "finished structure," but is not intended to serve as the roadmap to get there—those strategies will appear in companion documents and actions, and will evolve depending on opportunities available under the Affordable Care Act (ACA) and elsewhere. This Framework is intended for a broad community audience of consumers, care providers, policymakers, and

funders. It is meant as a tool to drive specific collaborations and partnerships that will move a transformed system of care to implementation.

Numerous agencies and partnerships in the King County community have already taken or are taking concrete steps to put in place the elements laid out in this framework. Going forward, the King County Health Reform Planning Team will leverage current efforts and work to strengthen existing collaborations to fill in what's missing and to accelerate progress.

While this framework represents a vision for all low-income residents in King County, current financial and policy realities suggest that not all individuals will have access to the necessary services and supports to achieve optimum health. Even with expanded health care coverage under the ACA, some individuals will remain uninsured or underinsured and continue to have limited access to health care relative to others. Furthermore, limited resources and funding mandates, including stringent eligibility criteria, prohibits access to some services for some people. Despite this reality, the King County Planning Team is committed to promoting equitable access to health and social services and will develop policies that promote a system of care that strives to provide needed services to residents whenever possible.

Vision: An Accountable System of Care for King County's Low-Income Residents

For low-income residents of King County, the transformed system of care will place the individual at the center. Care will be coordinated through a person-centered medical home—sometimes also called a health home—that provides for or assures a broad range of culturally appropriate, integrated preventive, medical, dental, behavioral health, and social services – with a single point of accountability. This medical/health home will be embedded in a broader integrated system of care that includes access to an array of social services including housing assistance, employment, basic needs, family support services, legal assistance, income assistance, and crisis services. Healthy community environments will encourage recovery and promote individual and community wellness for all residents.

The entire system of care will be responsible for the achievement of health and wellness goals for residents, and for managing costs. Proactive work with the payment, regulatory, and information technology systems at the local, state, and federal level will help assure that they support and enable this vision.

FOUR CORE CAPABILITIES OF A TRANSFORMED SYSTEM OF CARE

The following section describes the core elements identified as necessary to transform the system of care in King County and achieve the overall vision of the King County Health Reform Planning Team.

1. Care will be organized around the individual in a way that best supports their health.

Across the U.S., the health care crisis is driving new models of person-centered care that are showing they can deliver greater satisfaction for individuals and families, better health for the residents, and lower costs. Central to the transformation is the person-centered medical home or health home, a comprehensive approach to organizing primary care. Individuals have an ongoing relationship with a primary care provider and care team, which collectively take responsibility for providing and coordinating all of the person's health care needs including primary and specialty care, behavioral health services, health promotion, and chronic care management. This approach counters the historic fragmentation, waste, and inefficiencies of our health care system, and holds promise for improving health of all county residents, regardless of income level.

Because low-income residents face greater inequities in health, access to a person-centered medical home is particularly important. In the King County system of care, individuals will get the right care at the right time in the right place, in a culturally and linguistically appropriate manner. Care will be coordinated across providers, and smooth handoffs will occur when individuals transition from one setting to another. A single plan of care, single problem list, and a single medication list shared among all members of an individual's care team will help assure high quality, efficient, and well-coordinated services. The team will work to assure integration of primary care, oral health, behavioral health, prevention and health promotion services, and social services. Integration of mental health and substance abuse services is especially critical to design, both by integrating behavioral health into primary care, and by integrating primary care into behavioral health settings where needed in order to meet individual needs. Finally, access will be improved through health coverage, convenient hours, transportation help, electronic health records, and the use of mobile services and telemedicine where appropriate. Formal recognition of medical/health homes will be encouraged to help assure consistency and quality of these services and practices.

The King County system of care will intentionally create environments where individuals are actively involved in self-management and shared decision-making and where their preferences are honored. Education, technology, and training for individuals, family members, and staff will support this empowerment and engagement.

2. Robust system of care management for those with chronic health conditions

Chronic health conditions are those that persist for a long time, examples of which include asthma, diabetes, cancer, epilepsy, mental health and substance abuse disorders, HIV/AIDS,

and hepatitis, among others. In most cases, care for individuals with chronic health conditions is paid for by multiple funding streams in multiple service systems (i.e., medical, mental health, substance abuse and/or long-term care). As a result, care is often fragmented and difficult to navigate. Many individuals with chronic health conditions have multiple needs that may overlap and impact one another, and a lack of coordination too often results in poor health outcomes and costs that could have been avoided To address these challenges, intensive care coordination that works across service domains and disciplines is an essential ingredient in a transformed system of care.

The King County system of care will assure that care management, including self-management support, is organized in a systematic, rational way that prevents duplication and assures integration with the medical home. For high-need individuals with complex chronic medical, behavioral health, and social needs, the King County system of care will ensure a targeted and intensive care management model that identifies and engages individuals, and manages both health and social service needs, including housing stability. Care managers will help support safe and high quality handoffs when people transition from one care setting to another. Where needed, care management services will be capable of providing "high touch" (in person), community-based support through low caseloads and use of interdisciplinary teams that involve medical, mental health, substance abuse, long-term care, and peer support services. For those with chronic health conditions who fall into a lower tier of need and risk, chronic disease self-management support, wellness coaching, and related services will be available, both in the clinic and in the community.

3. The delivery system will increasingly offer services through culturally appropriate community hubs organized around the needs of individuals.

For many individuals within the safety net, unaddressed social needs and health concerns often go hand in hand. Typically referred to as the social determinants of health (SDOH), factors such as affordable and safe housing, family wage jobs and job training, healthy built and natural environments, and quality education have significant impacts on the overall health and well being of individuals and communities. A coordinated system of care combines not only medical and behavioral health services but includes integration of social services and supports to address the whole person in a culturally and linguistically appropriate manner. More coordination linking residents to needed social services can improve their lives and lead to lower health care costs, a win-win for the individual and the community.

In a transformed system of care, a series of community hubs will be in place throughout the county that include integration and rapid access to a wide range of services and supports. For example, individuals will experience easier pathways into health services, insurance coverage, housing assistance, employment, family support services, legal assistance, income assistance, basic needs, crisis services, and more. Going beyond co-location of services, hubs will strive to serve as focal points for community wellness, incorporating opportunities for physical exercise,

access to healthy foods, classes on living well with chronic conditions, or other elements tailored to the given community. In our community today we have many successful partnerships among community health centers, behavioral health agencies, public health, housing and human service agencies, and community development programs upon which to build. They provide a critical basis from which can evolve into an even more comprehensive approach to improving individual and community wellness.

4. A prevention, wellness, and recovery orientation will infuse the system of care as well as the community environment.

Ultimately, successful transformation of the King County system of care means shifting from a system focused primarily on treating illness to one focused on *preventing* illness and promoting recovery and resiliency. Therefore, services to prevent disease, detect health problems early, and support wellness and recovery will be integrated into the system of care and be clearly visible within the community hubs. Prevention, wellness and recovery services will also be provided in community settings, such as schools, work sites, social service programs, and housing. Preventive services will reach individuals across the lifespan. To lower the risk of future health problems, King County will promote optimal early childhood development and provide early intervention services.

In addition to individual-level preventive services, the system of care will focus on improving the conditions of our communities – the places where people live, learn, work and play – through policy and system change tools. The King County system of care will work across such sectors as health, housing, transportation, land use, and community and economic development to create healthy, safe community environments that will in turn support greater equity in health for all residents of King County. Improving communities means improved health, increased productivity, and greater environmental sustainability.

CORE INFRASTRUCTURE NEEDED TO SUPPORT AN INTEGRATED SYSTEM OF CARE

The four core elements above lay out the new way the King County system of care will partner with individuals and communities to improve health—a new way of doing business in health and human services that will create better health while controlling costs. To carry this out, several critical infrastructure components are necessary to ensure effective service delivery changes. This section describes five core infrastructure components that must be put in place to achieve the overall vision.

1. A transformed workforce to carry out this work.

New types of workers with new skills are needed to carry out the culturally appropriate, consumer-driven approach to services described above, and to reduce the health inequities that are especially marked in King County compared to other large U.S. counties. To help

achieve this aim, King County and its partners will work to advance the field of community health workers and peer support workers, trained staff who share or have close ties to the cultural, community, and life experiences of the individuals they work with. This new workforce will be in widespread use, linked to medical homes, care management services, and prevention initiatives to support individuals with access to insurance coverage, system navigation, advocacy, health education, disease self-management, and linkage to social services. In addition, the King County system of care will ensure an adequate and well-supported primary care and behavioral health workforce to serve individuals in the safety net population including support for training in care coordination and interdisciplinary team functions.

2. Health information technology infrastructure to support this work.

To carry out the expectations of the medical home, including good care coordination, electronic tools are needed to help support the rapid movement and sharing of client information. Electronic health records will be in use across health safety net providers in King County, including behavioral health providers. Providers will be able to view and exchange clinical data electronically, and individuals will be able to access personal health records to support them in better managing their own care. Technology will also be used in innovative ways throughout the county to support health promotion and disease self-management, and to help overcome linguistic and transportation barriers. Providers, payors, and public health will use aggregate data to drive improved quality and efficiencies, and to reduce inequities.

3. A supportive financial, policy, and regulatory environment.

In a transformed system of care, funders will transition from paying for volume to paying for value. Base payments will fund prevention, treatment and care management costs. Financial policies and practices will align with the Triple Aim of better health, better quality and reduced costs, to assure that individuals have easy access to the care that they need; promote better health by paying incentives to health care providers who achieve positive health outcomes for and with the individuals they serve; and promote reduced health care costs by fostering efficiencies that create savings that can be shared among providers and reinvested in building community capacity.

Looking beyond the health care delivery system, the King County system of care will strive for a policy environment that better supports the development of healthy communities: equity criteria will systematically become part of our community decision making processes so that gaps in health outcomes by income groups, geographic areas and race/ethnicity can be closed over time.

4. Performance measures and accountabilities to support achieving the triple aim.

Providers will commit to measurement-based treatment to target and the use of evidence-based and evidence-informed care. This includes each individual having a treatment plan with clearly established and measurable goals. Each individual's progress on personal goals and

clinical outcomes will be routinely tracked and monitored. Similarly, there will be a commitment to measuring improvements at the population level that include the overall health of community environments. Since population health measures may take years to change, it will be important to measure intermediate steps along the way and evaluate how well community improvement initiatives are working as they are implemented and spread.

5. Leadership and commitment to work together in new ways.

Finally, we must all be willing to lead the way to health improvement. Individuals, families, and communities will have to play stronger roles in promoting their own health and wellness. Health and social service organizations will need to partner in different ways and shift their workflows, focusing on quality, outcomes, and coordination. And funders will need to coordinate with each other to better support and encourage these innovations and improvements over time.

On June 25, 2012, this framework was endorsed by the King County Health Reform Planning Team. Endorsement means support for the concepts and a willingness to work in ways that support its realization. It does not imply financial commitments. If your organization would like to be involved in moving this vision forward, please join our efforts. Contact Jennifer DeYoung or Susan McLaughlin for more information about how to get involved.

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King County Health Reform Planning Team Vision

Create a Transformed System of Care with a Single Point of Accountability for Low-Income Residents

Through person-centered medical home, intensive care management, comprehensive community hubs, and prevention and wellness.

Priority Areas of Focus for Achieving Vision:

Access

Ensure residents obtain coverage

Action items:

--KC leading efforts to engage entire community in enrollment

Capacity

Ensure system of care can provide the right care at the right time in the right setting

Action items:

--Measure and monitor current and future system capacity

--Identify new types of workers and skill sets necessary to support transformed system

-- Ensure infrastructure exists to support transformed system of care including IT mechanisms

Delivery System Integration

Promote effective and efficient integrated delivery systems of care

Action items:

--Promote robust health home network implementation (underway)

--KC continued exploration of Duals Strategy 2 initiative (underway)

--Develop strategies to integrate human services "health neighborhood" into healthcare system (underway)

--Create a demonstration learning system for integrated system of care in KC

Resources

Sufficient resources to achieve the Framework vision and meet residents' health and human service needs

Action items:

--Track federal/state policy for opportunities to secure resources for our community

--Develop legislative strategies for health, human services, and public health funding

--Planning for retooling/reprioritizing of existing resources given health reform shifts

--Includes: service resources; workforce development; IT development; community prevention

Education

Ensure the safety-net consumer and provider community understands how health reform will impact them

Action items:

--Create tools providers and/or consumers could use to help understand their role and how to respond to HR

--Develop mechanisms to expedite the flow of information on HR

--Promote leadership and commitment to work together in new ways

Materials for Item 12 will be distributed at the meeting.